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Sex is a problem for everyone . . . Indeed, for a couple of weeks or a couple of months, or maybe even for a couple of years, if we are lucky, we may feel that we have solved the problem of sex. But then, of course, we change or our partners change, or the whole ballgame changes, and once again we are left trying to scramble over that obstacle with this built-in feeling that we can get over it, when actually we never can. However, in the process of trying to get over it, we learn a great deal about vulnerability and intimacy and love. . . .

(Peck, 1993, *Further Along the Road Less Traveled*)

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## INTRODUCTION

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The primary care provider is in an optimal position to evaluate sexual problems, since he or she often has the most comprehensive and long-lasting relationship with the patient. In contrast to most other medical diagnoses, however, it is the patient who usually defines when a sexual problem exists. Although referral to medical or mental health specialists (or both) may be indicated in certain situations, many problems can be diagnosed and treated by the primary care practitioner. When questions about sexuality are approached in an open, matter-of-fact manner, most patients are relieved and respond positively. They appreciate the affirmation that these issues are valid and important, whether or not they have current sexual concerns or are sexually active (Table 28-1).

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## CHALLENGE FOR PRIMARY CARE PROVIDERS

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Providing patients with helpful responses to their sexual health concerns requires that health professionals have:

- Willingness and ability to discuss sexual topics comfortably.
- Awareness of the range and diversity of human sexual practices and concerns, as well as the importance of the circumstances or conditions under which individuals function best.
- Ability to separate one's own personal beliefs and values from those of patients. Unless the practitioner encounters information indicating objective harm to someone involved, it is important to maintain a nonjudgmental demeanor.
- Skill at taking a sex problem history in appropriate detail.
- Knowledge of simple interventions, such as permission-giving, transmittal of accurate information, specific suggestions (eg, for making sex less pressured and more pleasurable), and making referrals to other resources, when appropriate.

Health professionals may have limited sexual experience, as well as questions and problems of their own, and a consequent discomfort in discussing particular sexual material. Time, thought, and experience, however, can build confidence and expertise in talking about sexual problems. Providers can increase their comfort level by examining their own attitudes, beliefs, assumptions, and experiences; reading in the literature (see Patient and Professional Bibliographies at the end of this chapter); discussing these issues with friends and colleagues; and routinely incorporating sexual health questions into the general health assessment of patients.

Of course, no one—patients or caregivers—should be forced to talk about sexuality. It is important for all of us to recognize the limits of our own interest, comfort, and competency. Sexual health is an integral part of health care, however, and all who deal with patients should be alert to the possibility of sexual concerns and at the minimum be able to respond with nonjudgmental listening and reassurance or by referring to a colleague who is comfortable and competent in discussing sexual issues.

Table 28-1. Sexual concerns of patients.

- **Common sexual worries about normalcy**, such as: *Am I O.K.? What is a "healthy" sex life? How do I compare? Is my sex life satisfactory?*
- **Sexual identity questions** relevant to life-style, orientation, and preference.
- **Developmental issues of sexuality** for children, adolescents, parents, and the elderly, including the development of gender identity, masturbation, genital exploration, child sex play, sexuality and the single life, marriage, divorce, and death of a partner.
- **Reproductive concerns** covering infertility, family planning, contraception, pregnancy, and abortion.
- **Sexual desire, satisfaction and dysfunctions**, such as a couple's differing levels of desire, and problems with vaginal lubrication, erections, orgasm, and pain.
- **Sexual changes** due to physical disability, medical illness, and treatment.
- **Sexual trauma** resulting from molestation, incest, and rape.
- **Safe sex practices**: AIDS and sexually transmitted diseases.
- **Paraphilias and sexual compulsions**.

## PERSPECTIVES ON HUMAN SEXUALITY

Although a knowledge base of human sexual response is developing, even the most scholarly sexual research is rarely value-free. Sexuality encompasses an enormous range of behaviors, beliefs, desires, experiences, and fantasies that patients may discuss with their health care providers. Sexuality can also have legal, medical, moral, political, and religious aspects. It is difficult to find a more controversial area of human experience!

Motivations for human sexual expression are complex and numerous, existing throughout the life cycle in times of illness as well as health, varying from culture to culture and from individual to individual. They include the need to express love, and the need for physical release, reproduction, recreation, and to increase self-esteem. Conversely, sexuality can also be used to coerce, control, or degrade others.

Sexual worries or difficulties are probably experienced by all of us at some periods in our lives and may result from developmental growth and changes in life circumstances rather than from pathology alone. Sexual problems are sometimes a blessing, such as when they compel a person to get help for symptoms that indicate underlying problems with self-esteem or with a relationship. For some people, seeking help for an erection or orgasm problem may be more acceptable than for self-esteem issues such as not liking themselves.

Since the language of sex is broad and varied, it is helpful to become familiar and comfortable with the vernacular and to be able to discuss calmly and in detail such matters as masturbation, sexual positions,

oral sex, anal sex, penis size, and breast size. The following section discusses a few of the areas in which misconceptions can be resolved.

## COMMON MISCONCEPTIONS

From a medical viewpoint, masturbation is "normal," universal, and physically harmless at all ages. It is highly correlated with self-acceptance and sexual adjustment, and is often used to further sexual self-awareness in sex therapy. Some people freely choose not to masturbate, perhaps following personal or religious tenets. Guilt about masturbation, however, continues to affect many patients. Less frequently, one may encounter patients who use masturbation compulsively to avoid authentic relationship issues, or sex offenders who reinforce their antisocial fantasies via masturbation.

There is no standard for what constitutes acceptable sexual frequency. Individuals who are celibate may still consider themselves sexual beings, whereas others may have sex rarely but find it satisfying and enjoyable when they do. Compulsively frequent sex can become unrewarding for some, whereas others thrive on a frequent and active sex life. What is "right" for a particular individual or couple must be determined by them based on the various meanings and expectations they associate with sex.

Sexual fantasies are limited only by human imagination and may be enjoyed for their own sake. They may be exciting to a person who would never want to experience them in real life, or they may be yearned for. Obsessive and intrusive images that cause discomfort may need to be addressed therapeutically.

The majority of women enjoy and need direct clitoral stimulation manually or orally to reach orgasm. Unfortunately, many men assume that their female partners only enjoy intercourse. A result of this overemphasis on intercourse is that many women and men are uncomfortable with genital caressing alone. Couples can benefit from encouragement and permission to learn about and enjoy noncoital sex.

Most gay, lesbian, or bisexual patients do not wish to have their sexual orientation changed or challenged and may present the same concerns as heterosexuals about normalcy, dysfunction, and intimacy (see Chapter 14).

Normal changes in sexual response with aging include the following:

1. More direct genital stimulation and more time is needed for arousal (lubrication or erection).
2. Women may experience irritation and pain with intercourse after periods of abstinence.
3. Erections may become less rigid.
4. Orgasm may not occur with each sexual encounter and the urge to ejaculate may become less intense.



aches, indigestion, headaches, or any specific symptoms of depression or anxiety) as a veiled request to talk about sexual concerns. Others mention a sexual concern at the end of a visit in an offhand manner, when there is no time for the problem to be adequately evaluated. The provider may then choose to assess the problem briefly and validate the importance of investigating this as soon as a new appointment can be scheduled.

Since sexual problems are often the result of a distressing gap between the patient's expectations and experiences, the effective sexual interview aims to elucidate both sides of the equation: if expectations are unrealistic, the treatment is education; if the experience fails to meet realistic expectations, intervention or referral is indicated. Often education and other clinical interventions are combined.

**Case illustration 1:** One couple sought help from a sex therapist because, after 30 years of enjoyable and satisfying sex (involving intercourse that would last less than 5 minutes), they had read an article extolling the virtues of extended intercourse and began to feel inadequate. When encouraged to value their own unique sexual patterns, versus what might be right for someone else, they were relieved and decided they didn't have a problem after all.

## SEX PROBLEM INTERVIEW

As with any other medical problem, five basic areas need to be addressed for the patient presenting with a sex problem (Table 28-2):

1. Explicit symptom or question
2. Onset and course of the symptoms
3. Patient's perception of the cause and maintenance of the problem
4. Medical evaluation, including medical history, past treatment, and outcome
5. Current expectations and goals for treatment

Answers to the preceding inquiries can help guide the clinician to specific interventions.

## PHYSICAL EXAMINATION

The detailed examination of the genitourinary system should include checking for signs of androgen or estrogen deficiency or excess, neurological dysfunction, genital abnormalities, and vascular disease. For men, this includes examination of the penis (to ex-

Table 28-2. Sex problem interview.

<b>Description of Current Symptom in Detail</b> <ul style="list-style-type: none"> <li>• Signal that you are glad the patient brought up the problem (to give approval, counteract shame, and encourage the patient).</li> <li>• Help the patient specify exactly what the problem is, being careful to use understandable language—low desire, not getting wet or lubricating, difficulty getting or losing a "hard-on" or erection, difficulty "coming" or having orgasm, "coming too quickly" or rapid ejaculation, etc.</li> <li>• <i>I'd like to ask a few questions to help us sort it out.</i></li> <li>• <i>Tell me what happens.</i></li> <li>• <i>How is that a problem for you?</i></li> <li>• <i>Anything else that has changed?</i></li> </ul>
<b>Onset and Course</b> <ul style="list-style-type: none"> <li>• <i>Does it happen alone with self-pleasuring or masturbation, with a specific partner, or with any partner?</i></li> <li>• <i>How does your partner respond when the problem occurs?</i></li> <li>• <i>Was there a time it was more enjoyable and then changed?</i></li> <li>• <i>Any situations when it's not a problem?</i></li> </ul>
<b>Patient's Perception of Cause and Maintenance of Problem</b> <ul style="list-style-type: none"> <li>• <i>Anything you think might be causing it or that you worry might be causing the problem or keeping it going?</i></li> </ul>
<b>Medical Evaluation, Past Treatment, and Outcome</b> <ul style="list-style-type: none"> <li>• <i>Do you smoke or use prescription or over-the-counter medications, drugs, or alcohol?</i></li> <li>• <i>Do you have any medical illnesses or treatments, depression, anxiety, or relationship problems?</i></li> <li>• <i>For women: Are your menses normal, regular? Have you had any children? Were any problems associated with pregnancy, delivery, breast-feeding?</i></li> <li>• <i>For men: Do you notice morning or nocturnal erections? Are they firm enough for penetration?</i></li> <li>• <i>Do you have a need for birth control; if so, what methods do you use?</i></li> <li>• <i>Are you concerned you might have gotten a sexually transmitted disease?</i></li> <li>• <i>Any history of physical, emotional, or sexual abuse?</i></li> <li>• <i>What have you already tried to help to change the problem?</i></li> <li>• <i>Have you ever had psychotherapy, couple or sex therapy? If yes, was this sexual problem addressed in the treatment?</i></li> <li>• <i>Have you discussed this problem openly with your partner?</i></li> </ul>
<b>Current Expectations and Goals for Treatment</b> <ul style="list-style-type: none"> <li>• <i>How important is it to you to get help with this problem and are you interested in trying to change it now?</i></li> <li>• <i>What would be the minimum improvement you would need in order to feel it was worth your time and effort in dealing with this problem?</i></li> <li>• <i>Most everyone has sexual concerns at one time or another. Talking about them is the most important first step. I'm glad you've felt comfortable talking with me and I suggest . . . (or will suggest some things after I've had a chance to review the best resources for you). Many people have been helped with these issues.</i></li> </ul>

clude conditions such as Peyronie's disease, penile discharge, and hypospadias); testes and scrotum (for masses, atrophy, hernia, or varicoceles); skin, prostate, and rectum; and testing for evidence of gynecomastia, peripheral vascular disease, and neuropathy. Testicular self-examination should also be taught.

For women, the examination should look for evidence of atrophic vaginitis; vaginal atresia; defective vaginal repair; pelvic inflammatory disease; endometriosis; and signs of cystitis, vaginitis, urethritis, and vulvitis. For dyspareunia, the patient can use a mirror to help identify painful areas. Breast self-examination should also be taught.

When pathology can be excluded, patients can be reassured that their genitals look "quite healthy" and are in the normal range. This can help counter the shame that many people feel about these vulnerable areas of the body. Naming specific genital parts, such as the foreskin and glans of the penis and clitoris and labia, may give increased permission for the patient to ask any questions or express any concerns they may have about them. Men concerned about the size of their penis or women with worries that their genitals are somehow abnormal are more likely to voice these concerns after the clinician has comfortably used these words.

## LABORATORY TESTS

In general, few laboratory tests are necessary for patients presenting with the most common sexual problems. For complaints of low sexual desire, patients should be screened for depression and tested for anemia, endocrine, liver and renal disease, or any other debilitating medical problems suggested by the history and physical examinations.

Tests for women with sexual problems might include measurement of serum estradiol (<35 ng/mL is predictive of low sexual frequency), follicle-stimulating hormone (FSH), prolactin, luteinizing hormone (LH) levels, and androgen.

Some authorities recommend evaluation of serum testosterone and prolactin levels in all male patients with erectile failure or low libido. Elevated prolactin levels can be the result of many medical conditions, including pituitary tumors; renal dysfunction; sarcoidosis; thyroid disease; trauma; pelvic surgery; or use of medications such as cimetidine, haloperidol, and phenothiazines. If any of these tests are abnormal or other endocrine problems are suggested by the history or physical examination, the additional relevant tests should be performed.

Depending on the problem, additional diagnostic studies for men with erectile dysfunction may be conducted by a urologist and include monitoring of nocturnal penile erections (NPT) in a sleep laboratory or, more commonly and less expensively, with

a home monitoring unit or simple snap-gauge. Increasingly, urologists have been using intracavernosal injection of local vasodilators such as prostaglandin E<sub>1</sub> (PGE<sub>1</sub>) to assess penile tumescence. In the future, oral vasodilators and those delivered intraurethally may also be used diagnostically as well as for treatment.

## ORGANIC & PSYCHOGENIC FACTORS

Rather than describing sexual problems with a simple differential diagnosis of either organic or psychogenic etiology, it is useful to identify *both* categories of causal factors. These can be assessed with the psychosocial history, sex problem interview, physical examination, and laboratory testing. A symptom that is generalized (occurring in all circumstances) may indicate major organic or psychogenic involvement, whereas situational symptoms tend to be psychogenic (Table 28-3).

### ORGANIC FACTORS

Organic factors may be suspected when a man reports an absence of nocturnal or morning erections or is unable to get erect with masturbation. For painful intercourse, important situational variables to identify include whether the woman has been adequately stimulated and aroused prior to penetration, whether she feels pain with masturbation or when having sex with another partner, and whether she is able to direct the extent and timing of thrusting or is passive. Also, organic factors should be considered when a patient has not responded to an adequate course of sex therapy.

### Medical Conditions & Treatments

Medical conditions and treatments affecting sexuality are listed in Tables 28-4 and 28-5.

Table 28-3. Symptom patterns and etiology.

#### Symptom Patterns Suggestive of Principally Organic Etiology

- Generalized (especially for absent desire, erectile disorder, secondary premature ejaculation and painful intercourse. Even when generalized, however, primary rapid ejaculation and primary female orgasmic disorder in otherwise healthy individuals are rarely organic)
- Gradual onset
- Rapid onset when associated with certain medications

#### Symptom Patterns Suggestive of Principally Psychological Etiology

- Situational
- Rapid onset (unless medications are suspected)
- Sexual phobia and aversion

**Table 28-4. Medical conditions commonly associated with sexual disorders.**

- Arthritis/joint disease
- Diabetes mellitus
- Endocrine problems
- Injury to autonomic nervous system by surgery or radiation
- Liver or renal failure
- Mood disorders, including depression, anxiety, and panic
- Multiple sclerosis
- Peripheral neuropathy
- Radical pelvic surgery
- Respiratory disorders (eg, COPD)
- Spinal cord injury
- Vascular disease

COPD = chronic obstructive pulmonary disease.

### Medications

Medications of many kinds have been implicated in sexual dysfunction (Table 28-6). Older antidepressants such as amitriptyline (Elavil) and doxepin (Sinequan) have anticholinergic properties that undermine sexual arousal. The newer and widely used selective serotonin-reuptake inhibitors (SSRIs)—antidepressants such as fluoxetine (Prozac), sertraline

(Zoloft), and paroxetine (Paxil)—may inhibit orgasm for women and ejaculation and orgasm for men. Strategies to alleviate such dysfunction include (1) reducing the dosage; (2) taking a weekend “holiday” in which the last dose for the week is taken on Thursday morning and the medication is resumed at noon on Sunday; (3) switching to another medication; or (4) coadministering other medications, such as neostigmine (Prostigmin), cyproheptadine (Periactin), bethanechol (Duvoid), and yohimbine (Yohimex) 1–2 hours prior to sexual activity. Newer antidepressants will hopefully become available in the future with effects equal to the SSRIs yet with fewer sexual problems.

### PSYCHOLOGICAL FACTORS

Psychological factors often play a causal role in maintaining the sexual dysfunction even when there has been identification of a medical condition or medication commonly known to cause problems (Table 28-7). For example, a female patient experiencing

**Table 28-5. Reversible and irreversible organic causes of sexual disorders.**

#### Potentially reversible medical conditions

1. *Low desire due to endocrine deficiencies:* testosterone deficiency (common in older males); thyroid deficiency (rare). (*Treatment:* hormone replacement)
2. *Low desire due to endocrine secreting tumors:* prolactin-secreting tumors of the pituitary (relatively common); estrogen-secreting tumors of the testes and adrenals (rare). (*Treatment:* medical, surgical, and radiologic treatment of the tumor)
3. *Low desire due to depression and stress* (common). (*Treatment:* psychotherapy, antidepressant medication)
4. *Low desire due to substances* (common): centrally acting beta-adrenergic blockers, centrally acting antihypertensive agents, excessive alcohol and narcotics. (*Treatment:* substitution of alternative medications; treatment of substance abuse)
5. *Vaginal dryness or atrophy* and discomfort on intercourse due to estrogen deficiency (very common in postmenopausal women). (*Treatment:* estrogen replacement, oral or local, dilation, and use of lubricants and vaginal moisturizers)
6. *Erectile disorder due to antihypertensives or other medications* (very common). (*Treatment:* reversible only if blood pressure can be controlled by diet, relaxation, and physical exercise, lifestyle changes, or substitution of other medications with lesser sexual side effects)
7. *Erectile disorder* due to blockage of large vessels supplying the penis (rare). (*Treatment:* vascular surgery)
8. *Organic erectile disorders due to other organic factors.* (*Treatment:* PGE<sub>1</sub>, penile injections, penile implants, oral vasodilator medications under clinical study and possibly available in 1998)
9. *Vaginal obstructions* due to vaginal agenesis, imperforate or rigid hymen. (*Treatment:* stretching, dilation, surgery)
10. *Female dyspareunia* due to vaginal infections, bladder infections, PID. (*Treatment:* antibiotics) Endometriosis. (*Treatment:* hormonal, surgical) Painful hymenal tags, episiotomy scars. (*Treatment:* surgery)
11. *Male dyspareunia* due to prostate infections, vesicular infection, urethral infection and tumors, hernia, chordee, penile infections, herpes. (*Treatment:* antibiotics, surgery)
12. *Arousal and orgasm disorders* due to reversible neurologic conditions caused by (a) vitamin deficiencies. (*Treatment:* vitamin replacement); (b) neurotropic viral infections. (*Treatment:* supportive management)
13. *Delayed or absent orgasm* due to SSRI and MAOI antidepressant medication. (*Treatment:* periodic drug “holiday,” lower dose, substitution of other medication, or coadminister other medication)

#### Medical conditions that are not reversible but that should be actively managed or treated in order to prevent further progression of the disease and further deterioration of sexual functioning

1. *Diabetes*, attention to glucose control
2. *Hypertension*, with its high risk of arteriosclerosis of the small blood vessels
3. *Vaginal atrophy*, secondary to pelvic irradiation and surgery. (*Treatment:* dilation and frequent sexual intercourse; estrogen cream when not medically contraindicated)

#### Common conditions not reversible or controllable with present methods

1. *Small vessel arteriosclerosis* of the penile vessels and corpora cavernosa (very common)
2. *Diabetic damage* to vessels and nerves involved in the erection and orgasm reflex (very common)
3. *Degenerative neurologic diseases* and injury to the central nervous system and surgical trauma to the nerves and anatomic structure involved in the genital reflexes (rare)
4. *Erectile disorder* and diminished libido associated with renal dialysis
5. *Drug-related erectile disorder* when no effective substitute without sexual side effects is available

Source: Adapted, with permission, from Kaplan HS: *The Evaluation of Sexual Disorders*, Brunner/Mazel, 1983.

**Table 28-6.** Medication and drug categories commonly associated with sexual disorders.

• Alcohol	• Pain medications
• Anticancer drugs and hormones	• Psychedelic and hallucinogenic drugs
• Anticonvulsants	• Psychiatric medications (benzodiazepines, tricyclic antidepressants, monoamine oxidase inhibitors, selective serotonin reuptake inhibitors, antipsychotics, lithium carbonate)
• Antihypertensives, including beta blockers (at high dosage), excluding ACE inhibitors	• Recreational drugs (tobacco, alcohol, and opiates)
• Carbonic anhydrase inhibitors	• Sleep medications
• Cytotoxic drugs	• Tranquilizers
• Digitalis family	
• Diuretics	
• H2 receptor antagonists	
• Nonsteroidal anti-inflammatory agents	
• Opiates	

difficulty reaching orgasm since being treated with an SSRI antidepressant may continue to have this problem even after switching to a lower dosage or different medication, because of a conditioned performance anxiety.

Following hysterectomy, some women report increased sexual enjoyment because of the relief from uncomfortable physical symptoms and bleeding, whereas others find the surgery difficult and have a psychological response to the loss of these organs and to their reproductive capacity. These women may then experience a decrease in sexual desire, arousal, or orgasmic responsiveness. The research is mixed as to the effects of hysterectomy on orgasm in women; it has been proposed that women differ in the extent to which they perceive uterine and cervical contractions during orgasm, with differing sense of loss after the

surgery. There is similar variability in men after prostatectomy. For many, orgasm may feel satisfactory even with a "dry" or retrograde ejaculation, with semen going into the bladder, but others may complain of a loss of orgasmic sensation.

*Case illustration 2:* Juan, a 38-year-old male patient, complained of erectile dysfunction with a possible organic component (type II diabetes) and performance anxiety. When he quit smoking cigarettes and tried non-coital caressing to decrease his pressure to perform, he was able to experience satisfying erections firm enough for intercourse. In this case, the diabetes by itself was not the determining factor in maintaining the problem.

Some medical illnesses and treatments are believed decrease sexual desire or to cause sexual dysfunction directly. Psychosocial adaptations to virtually any medical condition, however, can indirectly affect sexual desire or functioning. For example, fears of rejection by a sexual partner because of a stoma or mastectomy, or concerns about sexual functioning may lead to a suppression of sexual feelings and avoidance of sexual opportunities. Of course, many medical healthy men and women either choose to be sexually inactive or refrain out of a sense of inadequacy. The capacity to enjoy one's sexuality cannot therefore be predicted on the basis of medical diagnosis alone.

Psychological problems such as depression or anxiety can either be the cause or the effect of diminished sexual desire or functioning. Both may be true to some degree. In other instances, depression and sexual problems may both be the result of a third underlying factor, such as an endocrine disorder.

Sexual problems might have remote psychological causes, such as childhood trauma or prohibition about sexual pleasure, but almost all such problems can be seen as having current maintaining variables: anxiety or depression. In general, psychological etiology is primarily suggested when the problem is situational; seems related to performance anxiety, depression, or guilt; or is associated with significant relationship and communication problems.

## PSYCHOLOGICAL MANAGEMENT & BRIEF SEX COUNSELING

A paradigm shift occurred in the treatment of sexual dysfunctions with the publication in 1970 of Masters and Johnson's seminal work on sex therapy. The previous emphasis on the diagnosis and treatment of individual psychopathology, with somewhat poor treatment results for the sexual dysfunctions, gave way to an understanding of the importance of the conditions (internal variables such as attitudes, expectations, and lack of knowledge, as well as external factors related to the partner or the situation) under

**Table 28-7.** Psychological conditions commonly associated with sexual disorders.

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| I. Immediate causes (of most concern for the general medical practitioner)   |
| A. Performance anxiety—fear of inadequate performance  |
| B. Spectatoring—critically monitoring one's own sexual performance   |
| C. Inadequate communication with partner regarding sex   |
| D. Fantasy—absence of fantasy, antifantasy incompatible with sexual arousal, or distracting thoughts   |
| II. Deeper causes (for referral)   |
| A. Intrapsychic issues—early conditioning, sexual trauma, depression, anxiety, guilt, fear of intimacy, or separation  |
| B. Relationship issues—lack of trust, power and control issues, anger at partner   |
| C. Sociocultural factors—attitudes and values, religious beliefs   |
| D. Educational and cognitive factors—Sexual myths or expectations (gender roles, age and appearance, proper sexual activity, performance expectations), sexual ignorance |

Source: Adapted, with permission, from Plaut SM, Lehne GK: Sexual dysfunction, gender identity disorders, and paraphilias. In: Goldman HH (editor): *Review of General Psychiatry*, 4th ed. Appleton & Lange, 1995.

which people attempt to function sexually. Education and suggestions for focusing on pleasure rather than on performance were found to lower anxiety and to promote improved sexual functioning and enjoyment.

Anxiety is seen as one of the major psychological causes of the sexual dysfunctions, whether stemming from individual or relationship issues. Are patients comfortable, at ease, and feeling close to their partners? Or are they anxious due to lack of information, strained relationships, unrealistic attitudes about and focus on sexual performance goals, or other conditions? In these cases, modern sex therapy commonly provides anxiety-reduction interventions, many of which can be adapted for use by primary care providers. These include validating that sexual problems probably occur at some time or another to all of us and that such problems are often an understandable response to stress, worry, and concerns about performance; encouraging open communication between partners; dispelling maladaptive beliefs about sex; suggesting ways that patients can increase their level of comfort and safety and their ability to relax during sex; and encouraging the view that noncoital sex can be very satisfying and does not have to be considered "second-best."

## THE P-LI-SS-IT MODEL

Annon's P-LI-SS-IT model is a useful hierarchical guide to anxiety-reduction approaches to sexual problems and can be used by primary care practitioners. The letters in the acronym stand for different levels of intervention:

**P = Permission:** The fundamental intervention is to give permission to patients to discuss their sexual concerns. Empathic listening, including verbal and nonverbal reassurance, helps give patients permission to talk openly about sexual issues and may encourage and enable them to discuss the problem more directly with a partner. Reassurance and permission can help to normalize and validate that having a sexual problem can be part of being human, rather than pathological. Inquiry into positive exceptions: patients can describe those areas of sex that they do feel good about; for example, a woman can appreciate her ability to become aroused despite difficulty reaching orgasm, and a man can be a skillful lover despite his erectile disorder. Permission to choose not to be sexually active may be very helpful for patients who feel pressured to have sex or who feel inadequate if they don't care to be sexually active.

**LI = Limited Information:** Facts can add to the effectiveness of reassurance and can be at the disposal of any clinician who has done basic reading about sexuality and keeps up through the literature or review courses. Keeping responses focused and limited to the expressed concern saves time and does not overwhelm the patient with extraneous information (Table

28-8). Such information gives the patient the choice of maintaining or changing sexual practices or attitudes. A simple explanation of the psychophysiology of sexual arousal and the importance of conditions for relaxation helps "normalize" the symptom and refocuses the problem as stemming from conditions that can possibly be changed rather than from something that is wrong with the patient. This can be conveyed by the following "rhinoceros" story about sexuality:

Imagine you are lying on a blanket in a secluded meadow with a loving partner after having had a wonderful picnic lunch on a beautiful sunny day. You start kissing and feel arousal in your genitals, when, all of a sudden, a rhinoceros charges out of the jungle straight for you. What happens to your arousal (lubrication or erection)? The fight-or-flight response causes a rapid redirection of blood to the brain and large-muscle groups, with a corresponding loss of erection or genital arousal. The rhinoceros represents worrisome thoughts and anxieties about having erections, arousal, or orgasm, or fears that you won't please your partner or be seen as a good lover. Some simple suggestions can help you keep the rhinoceros out of your bedroom!

**SS = Specific Suggestions:** Where permission and limited information do not suffice, the patient may benefit from specific suggestions to help overcome a sexual problem. Most sex counseling interventions are designed to help the patient (and partner, if available) communicate better about sex and enjoy increased sexual pleasure by reducing performance anxiety about attaining the goals of arousal, lubrication, erection, and orgasm. Helpful interventions taken from sex therapy include (1) temporary agreement not to have intercourse; (2) suggestions for focusing on pleasurable touch, genital caressing, Kegel exercises (tensing and relaxing the pubococcygeal muscles) and progressive muscle relaxation methods; (3) correction of cognitive distortions ("self-talk"); and (4) suggestions to improve emotional and sexual communication.

Even for couples who initially enjoyed previous patterns of lovemaking, the predictable repetition of this sequence over time can lead to sexual boredom. Suggesting that a couple agree, for example, to temporarily forego intercourse or otherwise change their usual sexual pattern often helps them to focus on moment-to-moment pleasure. Rather than making assumptions about what the other wants, the couple can communicate about their likes and dislikes. Many people remember how arousing and exciting it was when they were younger and were "making out" (sexual petting) without intercourse. If agreeable to both, they can take turns exploring other ways of caressing and pleasuring each other. The *sensate focus* exercise, from Masters and Johnson, is done for the interest of the person doing the touching, rather than for the pleasure of the receiver. In order to minimize performance anxiety, each is encouraged to take turns "sa-



Table 28-8. Maladaptive ideas and therapeutic responses to them.

Maladaptive Idea	Therapeutic Response
My sexual problems are because I'm too old.	For those who are interested and willing to be creative, sex can be an enjoyable part of life in their seventies, eighties, and beyond!
I should only be interested in survival, not sex (for someone with terminal or chronic illness).	If sex was important to you before your illness it can remain so or become so again.
I am <i>asexual</i> because I don't have an active sex life.	We are <i>all</i> sexual beings. You can be aware of and enjoy your sexual feelings without being sexually active.
Sex equals love.	Many people have very loving relationships without being sexually active, and, of course, some people have sex without having loving feelings.
Sex equals intercourse.	There is no one <i>right</i> way to be sexual, and many people enjoy touching and caressing more than intercourse.
<i>Having sex</i> is the same as <i>enjoying sex</i> .	Many people have to learn to enjoy their sexuality.
It is not proper to talk about sex, either with your partner or a health care provider.	It is often a great relief when people can talk confidentially about their sexual feelings and concerns.
You shouldn't talk about sex because it will destroy the mystery.	Most people find that talking about their important feelings deepens intimacy, and trust develops when you know you can be vulnerable with another. You can create more mystery from deeper sharing.
You should be interested in having sex with any willing partner.	It is most important to be able to respect yourself. Your sexuality is a gift that you share only with those you truly want to share it with.
You should be able to enjoy sex with a partner even when you are tired, angry, or feel hurt.	We all have our own conditions for what makes a sexual encounter enjoyable, and feeling close to and loved by your partner is important to most of us.
I try not to masturbate and feel guilty when I give in because I have a partner and shouldn't need to do that.	Most married people continue to masturbate and find it does not interfere with the pleasure they have with their partner.
Sex is a performance, and it would be grim and catastrophic to "fail."	Sexual sharing can be playful, with the goals of giving and receiving feelings of pleasure and caring. If things don't go as planned, there is always next time!
A new partner will not like the size of my (breasts/penis).	Most men and women enjoy having sex with a person, not a body part. Most men compare themselves to other men when their penises are soft . . . size differences are usually not as great when erections are compared. Vaginas accommodate different penis sizes, with the outer third and the clitoris the most responsive areas for many women.
Sex should result in orgasm every time.	Does <i>not</i> having dessert ruin a fine meal? Orgasm is only one of the pleasurable aspects of a sexual encounter. Many people find it a relief to not have "should's" in their sex life.
Sex should never be a problem. Experiencing a problem is not normal.	Sex is perfectly natural, but not naturally perfect. Probably everyone has "problems" with sex at some time or another.

voring" the experience of touching and exploring the other's body, in contrast to worrying about "turning on" or performing for the partner. For many people, permission for genital caressing in this way increases sexual pleasure and satisfaction.

Arranging for follow-up after giving specific suggestions keeps the health care provider informed as to their effectiveness, helps the patient stay focused on problem-solving, and informs the clinician about the necessity for further intervention.

**IT = Intensive Therapy:** This is the last step in the hierarchy and involves referral to the appropriate

specialist when the previous three levels of intervention have not been effective (see later section).

### ADDITIONAL PATIENT EDUCATION

Pamphlets detailing approaches for safe sex for the prevention of AIDS can supplement discussion and should be made readily available for patients. Many good self-help books dealing with common sexual disorders enable patients to move at their own pace. Often people who are reluctant to enter counseling or

who are hesitant about discussing their problems in depth are willing to read in the privacy of their home where they can be relaxed and comfortable. Several books are recommended at the end of this chapter (see the Patient Bibliography).

## INDICATIONS FOR REFERRAL

Refer to an appropriate medical specialist if the brief treatment suggestions in this chapter fail to help or if the history and physical examination suggests primarily an organic component. Refer to a mental health specialist trained in sex therapy if the problem is situational, occurring only with a certain partner; if functioning is adequate under certain conditions; or if significant emotional distress is present.

Primary care clinicians can develop a resource list of providers for sex-related problems. Colleagues, teachers, friends, and clinical societies can be asked for recommendations. Identify medical and mental health specialists with expertise in treating sexual issues. Practitioners can be licensed in psychiatry, psychology, social work, psychiatric nursing, or marriage and family counseling. Most states do not license "sex therapists" or "sex counselors."

## COMMON SEXUAL DISORDERS

### LOW OR ABSENT SEXUAL DESIRE & SEXUAL AVERSION

The range of sexual desire issues is wide (Table 28-9). Some people simply put a low priority on sex, some are inhibited or find sex aversive, and some are clinically phobic. These problems can be of recent origin or reflect a long-standing pattern. Lack of desire may pertain only to certain sexual partners or practices (such as oral sex). Couples with a desire discrepancy may disagree about which partner's level of desire is "abnormal." In this situation, each side has valid feelings, and it is important not to stigmatize the patient with the lower desire level. Most couples deal occasionally with periods of desire discrepancy or of mutually low desire and feel they should have sex more often than they do. Demands of family, career, and friends often take precedence over sex.

Desire problems or sexual aversion can derive from deeper relational power struggles or reflect childhood sexual, physical, or emotional abuse that require couple counseling or individual psychotherapy for resolution. The following case example, however, demonstrates how permission and encouragement to talk about sex directly, together with specific suggestions, can have a powerful influence.

**Case illustration 3\*:** Alice, a healthy 33-year-old primary school teacher, reported having lost her desire for sex. Her sex problem history established that she had enjoyed sexual activity with her husband for the first 2 years of their marriage, although in the past year it had become a chore that she never put on her extensive "to do" list. Since sex was seen as a bedtime activity, when she was usually tired, their sexual frequency dropped from weekly to once every several months. While not addressing the problem directly, Alice and her husband's feelings of estrangement from each other were growing.

When asked what steps they had taken to address these problems, Alice disclosed that she and her husband had never had an open discussion about sex. Her primary care physician validated for her that this was frequently true for couples and that most people have to learn to talk more comfortably about their sexual needs (Permission and Limited Information). She also explained that everyone has certain conditions that need to be met in order to be interested in sexual activity (P and LI) and encouraged Alice to think about her conditions and then, with her husband, to "set some private time aside outside of the bedroom and let yourselves have a discussion about this, even if it is awkward" (Specific Suggestions).

**DOCTOR:** It can be good for relationships when people risk a bit of uneasiness. You don't have to have the same perspective. You are each entitled to your own separate feelings about the situation, but together you can talk it out, try to understand each other, and see what other choices you have. (P, LI, SS).

The physician also recommended a self-help book (SS) and offered to refer them to a therapist who treats couples, should their attempts to communicate falter (Intensive Therapy).

**Case illustration 3 (Contd.):** At her 1-month follow-up appointment, Alice reported significant progress. When the couple set time aside to discuss their sex life, they had a very meaningful and tender talk. The husband was relieved to learn about the major sources of Alice's lack of desire while she acknowledged her resentment that he seemed unresponsive to her needs. He admitted that he had taken her lack of desire very personally, secretly and painfully interpreting the problem as her lack of desire for him. With these hidden resentments expressed, they could set aside their power struggles and cooperate in addressing these issues. Recognizing how they had both felt lonely and uncared for allowed them to take specific actions, such as planning a regular evening each week just for the two of them to talk and nurture their intimacy.

\* Cases 3-10 described in this chapter were of actual patients seen in primary care settings as reported in consultation with the first author. Although some identifying characteristics of the patients have been changed to ensure confidentiality, the essential clinical issues presented are accurately portrayed. We thank all the patients and their health providers who helped us gather these examples.

Table 28-9. DSM-IV sexual disorders and treatment approaches.

Disorder	Diagnostic Criteria	Treatment Approaches
Hypoactive Sexual Desire Disorder (302.71)	Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and the context of the person's life.	After organic causes ruled out or if situational: <b>Permission and Limited Information:</b> (a) Restate problem in behavioral terms, (b) Explore patient conditions for good sex (rhinoceros story), including whether patient receives adequate direct stimulation, (c) Validate patient's right to say "no" to sex, (d) May be secondary to depression, anxiety, panic, or phobic disorder (occasionally related to childhood sexual abuse), or (e) May be symptomatic of hidden arousal or orgasmic disorder (if so, treat appropriately). <b>Specific Suggestions:</b> (f) Listening exercises to increase communication with partner, (g) Suggested readings (Barbach, 1976 and 1978; Gottman, 1994; Schnarch, 1989 and 1997; Zilbergeld, 1992). <b>Intensive Therapy:</b> Refer to mental health professional trained in sexual therapy.
Sexual Aversion Disorder (302.79)	Persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner.	
Female Sexual Arousal Disorder (302.72) Male Erectile Disorder (302.72)	Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement (female) or erection (male).	<b>Permission and Limited Information:</b> (a-d), above, (h) Give brief explanation of the physiology of arousal and the need for relaxation. (i) Is sexual desire present? (If not, treat as desire disorder). <b>Specific Suggestions:</b> (f-h), above, and (j) Enough and desired kind of direct stimulation by partner? (k) Use of lubricants (Astroglide, K-Y, etc) or vaginal moisturizers (Replens), (l) Suggest temporary intercourse ban, (m) sensate focus, (n) Genital caressing, (o) Progressive relaxation and Kegel exercises, (p) Explore ways other than intercourse of pleasuring partner, (q) Hormonal therapy, (r) Low-dose beta blocker (10 mg Inderal) if high performance anxiety, (s) Vacuum device, especially if organic and older male, (t) Intracorporeal penile injection or intraurethral application of PGE <sub>1</sub> , (u) Penile implant, (v) Future: vasodilator oral medications will be available.
Premature Ejaculation Disorder (302.75)	Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. The clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity.	<b>Permission and Limited Information:</b> as above, and explore masturbation patterns—may have conditioned himself to ejaculate rapidly. Explain connection between rapid ejaculation and anxiety versus relaxation and longer lasting erections. <b>Specific Suggestions:</b> (f-p), above, (w) Increase frequency of ejaculation, (x) Stop-start exercises (Zilbergeld, 1992), (y) SSRI antidepressant medication, (z) Prilocaine-lidocaine cream with condom, (v), above.
Female and Male Orgasmic Disorder (302.73)	Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. The diagnosis of female orgasmic disorder should be based on the clinician's judgment that the woman's orgasmic capacity is less than would be reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives. For the male, the clinician should take into account the person's age, and judge the stimulation to be adequate in focus, intensity, and duration.	<b>Permission and Limited Information:</b> (a-e), above. <b>Specific Suggestions:</b> For primary preorgasmic woman, recommend Barbach (1978); for male, Zilbergeld (1992). If orgasmic disorder is secondary (at one time patient was orgasmic), then evaluate and treat for desire or arousal disorder or relationship problems. (f) (j), (l-p), above.

(continued)

Table 28-9. DSM-IV sexual disorders and treatment approaches. (cont.)

Disorder	Diagnostic Criteria	Treatment Approaches
Dyspareunia (302.76) Vaginismus (306.51)	Recurrent or persistent genital pain associated with sexual intercourse in either a male or a female (dyspareunia). Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse (vaginismus).	<p><b>Permission and Limited Information:</b> (a-e), above.</p> <p><b>Specific Suggestions:</b> (f-k), (m-p), above, (aa) Encourage explicit communication with patient's partner about her need to have enough stimulation prior to penetration, give control to the woman to choose when penetration occurs and timing of thrusting.</p> <p><b>Intensive Therapy:</b> Sex therapy may be necessary for long-standing dyspareunia and vaginismus, due to conditioned expectation of pain.</p>

### Management

**Permission and Limited Information:** Some couples can learn to accept that low desire may be understandable given their immediate circumstances (eg, the months after childbirth) and that their previous levels of desire can be expected to return over time. Validate the patient's right to say no to sex.

**Specific Suggestions:** A "prescription" to go away on a weekend or to arrange a sleep-over for children with relatives may help couples "break the ice" and reexperience intimacy. Suggest that patient and partner set time aside to talk and listen to each other's feelings and conditions for more enjoyable sex, with each taking an uninterrupted amount of time for self expression. Self-help books may also be recommended.

**Other Medical Interventions:** Hormonal replacement therapy, especially testosterone, may be helpful for those with low levels. For example, vaginal application of testosterone cream may be useful to some women who experience a loss of desire following chemotherapy for breast cancer, unless otherwise contraindicated.

### FEMALE SEXUAL AROUSAL DISORDER

#### Symptoms & Signs

Problems with female arousal are primarily manifested as vaginal dryness and are reported less often than lack of desire, difficulty reaching orgasm, or pain with intercourse. The most common cause in older women is estrogen deficiency with resulting signs of vulvar irritation and atrophic vaginitis. Medication side effects also may inhibit arousal and should be explored (see Table 28-6).

*Case illustration 4:* Betty, a 78-year-old woman patient brought in her 82-year-old husband for her appointment with her female physician because she wanted to discuss what she called her "sexual problems." Betty said she did not care about sex, that her husband was often angry with her lack of enthusiasm, and that this pattern had existed

throughout the 50 years of their marriage. She believed she was not "a sexual person" because she had never been very excited by intercourse. She did enjoy kissing and caressing and mentioned that on several occasions she had been able to have orgasm when he stroked her labia and clitoris, but that she had never had orgasm from the "real sex" (intercourse) that he preferred. The physician responded that there really is no *one* way to be a "sexual person," that many people cherish the sensual and emotional aspects of sex, and that Betty did not need to consider herself asexual just because she preferred different aspects of sexual intimacy than her husband (P and LI). The physician further explained that the majority of women reach orgasm more often from manual caressing than from coitus, and that many couples enjoy bringing each other to orgasm without intercourse (P and LI). The couple was relieved and admitted to having curiosity about trying this petting more. They were given brief instructions to take turns at home touching and stroking each other without the goal of orgasm (sensual focus), to get reacquainted with each other's body, and to refrain from any attempts at intercourse for two weeks (SS).

A follow-up telephone call confirmed that they were enjoying taking turns caressing each other, that orgasm often happened for each, and that they occasionally progressed to intercourse. A 1 1/2-year follow-up was especially poignant—the husband reported that Betty had recently died from a stroke, and, while grieving her loss, he expressed profound appreciation for having gotten help for their sexual conflicts from the physician.

**HUSBAND:** Settling those old battles over sex made our last year together more loving and caring than ever before in our marriage.

### Management

**Permission and Limited Information:** Is the patient getting stimulation in the best way that works for her?

**Specific Suggestions:** Homework may be suggested for her to identify what stimulation works best. The goal is to experience the pleasure of arousal in that mode—not to reach orgasm. Inquiry should be made into the quality of the patient's relationship. Commercial lubrication (Astroglide, KY Jelly, etc) and vaginal moisturizers such as Replens can be suggested. Recommend self-help books.

**Intensive Therapy:** Recommend couple or individual therapy.

## MALE ERECTILE DISORDER

### Symptoms & Signs

Generally, a man with a significant psychological component is aware of nocturnal or morning erections, is able to maintain his erection for a reasonable time and then ejaculate with masturbation, or has good erections in some situations but not in others. He may be able to get a firm erection but lose it after penetration or may not get an erection with a partner at any time. The original cause of the problem is often distinct from the maintaining variable, which is generally anxiety. Consider possibilities such as performance anxiety, lack of direct physical stimulation of the penis, conscious or unconscious guilt (eg, "widower's syndrome"), anger at his partner or other relationship issues, and childhood sexual abuse.

*Case illustration 5:* Carl, a 58-year-old HIV-negative gay male, confided to his physician that he had been "impotent" since the death of his lover of 17 years, with whom he had had an active and monogamous sexual life. Attributing this problem to aging and worries about HIV infection, Carl nonetheless asked for any help the primary care physician could provide. A full session was scheduled for talking only. His partner had died suddenly from cardiac arrest a year ago. In the past month Carl had attempted sex on four occasions with two different men and was unable to get an erection. After a thorough sociosexual history, Carl was seen to fit the "widowers' syndrome." Clearly, he was still grieving the loss of his lover but attempted to control his tears with statements such as "I should be over this by now" and "Life has to go on; he wanted me to go on." Carl then revealed that he was very scared of feeling such loss, fearing that he would never be able to come out of the sadness. His grieving was acknowledged and validated (P), and it was explained to him that temporary sexual problems were common after such loss because of a number of factors: performance pressure of being with a new partner, continuing feelings of loyalty to a deceased partner, subsequent guilt at having sex with new people, and concerns about HIV infection with a new partner (LI). The physician encouraged Carl to join a grief support group or to contact a psychotherapist comfortable with gay sexuality (SS). In addition, the doctor referred Carl to a book on male sexuality, with suggestions for how he could talk with a potential partner about both safe sex practices and ways they could reduce the pressure to have erections (LI and SS). At a follow-up visit 4 months later, Carl reported he had been able to cry more about his loss and was enjoying sex and intimacy with a new friend who had also lost a partner.

### Management

**Permission and Limited Information:** Many patients over 40 years old report previous successful

sexual encounters when they were younger in which they became erect without direct physical stimulation of the penis. If their pattern for sexual interaction has rarely or never included direct touching by a partner, it might help them to learn that such touching becomes more necessary as men age, and that it can be an enjoyable part of sex.

**Specific Suggestions:** Institute a temporary ban on penetration and suggest sensate focus, progressive relaxation, and Kegel exercises. The couple should agree to *not* attempt penetration or intercourse even if the patient gets an improved erection.

**DOCTOR:** For every minute you are relaxing with your partner and have an erection, your body is remembering just what it needs to do to get and maintain an erection. Your mind can be free to enjoy the pleasurable feelings and sensations of being caressed and kissing your partner. You might even *allow* your erection to go away. If you stay relaxed, it will likely return again with resumed stimulation.

**Other Medical Interventions** *Testosterone replacement therapy.* For men with demonstrated low levels of serum testosterone, hormone replacement therapy may be helpful. This does not benefit men whose serum testosterone is within normal limits. Side effects can be serious, including increase of any existing prostatic cancer, enlargement of the prostate, retention of fluids, and liver damage. Careful monitoring and follow-up prostate-specific antigen (PSA) screening and prostate examinations are necessary.

*Yohimbine tablets.* Given in 5.4-mg doses three times a day for 4–6 weeks, this medication tends to stimulate desire and improve erections. Often suggested for men with suspected psychogenic etiology, yohimbine may help 15–20% of such patients. Side effects may include headaches, dizziness, and nausea. It is generally contraindicated for men with ulcers or hypertension.

*Antidepressant medication.* Antidepressants, especially trazodone, can be effective treatment for some, but other patients may find SSRI antidepressants to hinder erection and ejaculation.

*Low-dose beta blocker therapy.* Prescribed for men whose performance anxiety is very high, 10 mg of propranolol (Inderal) as needed has been effective with some patients.

*External penile vacuum device.* A tension ring is placed around the base of the penis after it has become erect with the aid of a vacuum cylinder. These devices may work better for men who clearly have a major organic component to their erectile problem, such as severe diabetes, multiple sclerosis, or spinal cord injury. Although this device can create erections functional for intercourse, men with a more psychogenic etiology may be disappointed when the results are not as firm as they had been expecting. Side effects may include bruising of the penis.

*Intracorporeal penile injections or intraurethral delivery of prostaglandin E<sub>1</sub> (PGE<sub>1</sub>).* Originally used diagnostically in urologists' offices, patients can now be taught to inject themselves prior to sexual encounters, resulting in firmer erections that often do not disappear at orgasm or ejaculation and last about an hour. Side effects are priapism in less than 3% of patients, and pain. In addition, scarring may be a concern with repeated injections over time.

*Penile implant surgery.* A variety of implants with semirigid silicone rods or inflatable cylinders are available. Total costs are high, ranging from \$6,000 to \$15,000. Complications include device failure (requiring additional surgery) and infection.

*Future oral pharmacologic agents.* Among the drugs currently undergoing phase III clinical research trials, the phosphodiesterase inhibitor, sildenafil (Viagra), taken as needed, shows promise for helping men attain and maintain erections with minimal side effects.

## RAPID EJACULATION (PREMATURE EJACULATION)

### Symptoms & Signs

Terms such as *rapid*, or *early ejaculation* are clinically preferable to the established *premature ejaculation*, since they highlight the subjective nature of the problem and are less pejorative. No absolute measure—either in number of minutes or thrusts—is applicable to the diverse numbers of men presenting with this problem. Factors to be assessed include a patient's subjective evaluation, degree of sexual satisfaction, and sense of control.

*Case illustration 6:* Donald, a 45-year-old divorced male reported ejaculating after 1 minute or less of intercourse. This had been his pattern ever since becoming sexually active in his late teens. He reported proudly that he never masturbated but had a high sex drive, which led him to multiple sexual partners including prostitutes. His primary care physician gave Donald a supportive talk about how he could teach himself to last longer with certain physical exercises (P,LI, and SS). The patient was willing to do "self-stimulation" or "self-pleasuring" exercises for this "medical reason" and was comforted that, as with the physical fitness regimen that he valued, he could tone up his pubococcygeal (p.c.) muscles and learn to relax the pelvic muscles during sexual stimulation. Donald was advised to increase his frequency of ejaculation, was told about the importance of relaxation for maintaining erection, and was encouraged to read Zilbergeld's self-help section on "stop-start" exercises for lasting longer (P,LI, and SS). As his confidence grew through the solo exercises, and as he increased the frequency of ejaculation, Donald was able to try the stop-start exercises with a partner with increasing success. He said that it also helped him to read about the experiences of other men (getting validation from the universality of sexual concerns) and about how many women enjoy a variety of forms of sexual stimulation in addition to intercourse.

## Management

**Permission and Limited Information:** Point out that early ejaculation is a very common problem—one study found 35% of married males reported that they ejaculated too quickly. Tell the patient that men with this problem have a high success rate when they try one or more specific suggestions that will be given to him for this problem. Give a *brief explanation of the psychophysiological mechanism*.

DOCTOR: Men aren't supposed to be able to have long-lasting erections if they are too nervous or distracted. The fight-or-flight response generally makes men more likely to ejaculate. Most men have trained themselves through rapid masturbation to get erect and ejaculate quickly; so it makes sense that they would continue to ejaculate quickly when with a partner.

Assure the patient that men often report more intense orgasms after they have learned to last longer and that it is highly likely that he will gain greater ejaculatory control by following these suggestions.

**Specific Suggestions:** The patient may need to *increase his frequency of ejaculations*, alone or with a partner, perhaps masturbating to orgasm earlier on a day that a sexual encounter with a partner is anticipated. Discuss *other ways he can please his partner*, so he doesn't feel pressure to do it all with an erect penis. Discuss the role of muscle relaxation as necessary to a prolonged erection. Suggest *breathing exercises and progressive muscle relaxation exercises*, targeting the p.c. muscles or those in the buttocks.

Suggest that, in contrast to common attempts by men to diminish the sensations in the hope of lasting longer, they actually need to *increase their tolerance for the good sensations and feelings* and can best do this by concentrating on their feelings and getting more "turned on." Focusing on these feelings in a relaxed "practice" atmosphere can lead to increasing the threshold of enjoyment before ejaculation and orgasm.

He and his partner can read about and practice the "*stop-start technique*." Encourage the patient to change positions and to go from intercourse to oral or manual stimulation of his partner, and then back to intercourse (following the desires of his partner); changing positions and pleasuring a partner to orgasm without intercourse helps many men last longer.

**Other Medical Interventions:** *SSRI antidepressants and clomipramine (Anafranil, 25 mg as needed)* help men prolong their erections prior to ejaculation.

*Prilocaine-lidocaine cream* applied to the penis and then used with a condom has been recommended by some clinicians (although "numbing" of the genitals may detract from enjoyment for both partners).

*New vasodilators*, currently in Phase III clinical trials, show promise for helping men attain and maintain erections with minimal side effects.

## FEMALE & MALE ORGASMIC DISORDER

### Symptoms & Signs

Many women do not learn to have orgasms until they are in their 20s, 30s, or even later. A **primary anorgasmic** or **preorgasmic** woman is not yet able to reach orgasm reliably either with a partner or by herself. A woman with **secondary orgasmic disorder** was previously able to reach orgasm but is no longer able to do so. **Situational orgasmic disorder** refers to a condition in which a woman can have orgasm with masturbation but not with a partner, or with one partner but not another. She may reach moderate to high levels of arousal without experiencing the pleasure and release of climax. If no arousal or interest is present, she should be evaluated for a desire or arousal disorder.

*Case illustration 7:* Ethyl's complaint of low sexual desire and difficulty feeling aroused led the physician to do a brief sex problem interview. With this more open discussion, Ethyl revealed that she had never been able to climax, but *had* been highly aroused in the first year of her 5-year marriage. Their lovemaking style was focused on intercourse, and Ethyl's husband didn't seem to understand why she didn't enjoy it as much as he did. She had not faked orgasm but had never told him about her feelings of frustration about not reaching orgasm. Ethyl had never masturbated and remembered vague attitudes conveyed by her parents and her church that masturbation was not a correct thing to do. The physician then validated that many women first learn about self-pleasuring as adults and that the information she could get about how her own body worked would then be useful in her sexual relationship with her husband. It was suggested that Ethyl read a self-help book for women who want to learn to have orgasms. (P, LI, and SS). At a visit 3 months later Ethyl reported that she had proudly experienced her first orgasm by herself and felt so encouraged by this that she was able to talk more openly with her partner, who then agreed to go with her to see a marital/sex therapist to discuss ways they could bring more pleasure into their own lovemaking.

For males, this *American Psychiatric Association Diagnostic and Statistical Manual*, 4th ed. (DSM-IV), category primarily refers to delayed or absent ejaculation despite prolonged intercourse or other stimulation. Some report ejaculation without the sensation of orgasm (see Table 28-9).

*Case illustration 8:* Frank, a 24-year-old man, confided that he had never reached orgasm with a partner. A sex problem history revealed that he had never ejaculated during intercourse and that his partners had never tried to bring him to orgasm manually or orally. Frank was able to ejaculate with masturbation, describing a vivid sexual fantasy (which he did not allow himself to have when with a partner) and a lifelong pattern of stimulation in which he rubbed his penis back and forth against a pillow without using his hands. He was congratulated

for bringing this problem to his physician's attention (P) and was told that anxiety was often a cause of this problem, together with a masturbation pattern that did not simulate the type of sensations he would have during intercourse (LI). The physician encouraged Frank to take a stepwise approach to the problem by enlisting the help of a willing partner and starting with those elements that had been successful for him. He was also encouraged to expand on the kind of physical stimulation he received during masturbation by gripping his penis with his hand and stroking it. With his partner, Frank was to focus on the goal of having high arousal while his partner stimulated his penis manually, and he was imagining his "tried-and-true" fantasy. The next step was to reach higher levels of arousal in this manner and to stimulate an orgasmic response (SS). Frank was also referred to a self-help book (P, LI, SS). Follow-up indicated that Frank had successfully reached orgasm with manual stimulation with a partner in 3 weeks and was following suggestions in the book on his goal toward ejaculation during intercourse.

### Management

**Permission, Limited Information, and Specific Suggestions:** Both men and women may present with orgasm difficulties because of a repeated pattern of masturbation that does not approximate the stimulation they receive from a partner. Although physical arousal may be apparent (erection or lubrication), these patients may not be feeling excited if they have to forego the fantasies or kinds of stimulation that had worked for them in masturbation. Encouraging them to incorporate the conditions under which they can reach orgasm alone into their sexual play with a partner is the first step in their expanding their sexual enjoyment. In some instances, use of a vibrator may be recommended to provide more intense stimulation needed for some people.

**Other Medical Interventions:** Currently, *oral vasodilator medications* being tested for managing male erectile dysfunction and premature ejaculation are also being considered for treating arousal and orgasm difficulties in women.

## SEXUAL PAIN: DYSPAREUNIA, VAGINISMUS, & MASTURBATORY PAIN

### Symptoms & Signs

**Female dyspareunia**—pain associated with penile-vaginal intercourse or other forms of vaginal penetration—may be one of the most common and perhaps most underreported of the female sexual dysfunctions. **Vaginismus**, the involuntary spasm of muscles around the vagina, may cause dyspareunia and is highly curable with psychological and physical interventions. The etiology of dyspareunia has had little if any systematic, controlled research. Manual-visual examination is of course important, but Meana and Binik warn against assuming that ob-

served pathology causes the pain. Also factors that originally caused the pain may not be the maintaining variables. Psychological causes of vaginismus vary and may include fears of penetration because of confusion about genital anatomy and physiology, or be the result of other trauma or irrational fears, causing a conditioned response of involuntary spasm of the vaginal muscles.

*Case illustration 9:* Nineteen-year-old Gina complained to her primary care provider that she had dyspareunia, was losing interest in sex, and was worried that her boyfriend was becoming impatient with her avoidance of sex. The physician then encouraged her to describe this problem behaviorally and in detail (P). Gina said that she had enjoyed intercourse since age 17 and always used latex condoms, but on one occasion 6 months ago she suddenly felt as if her vagina "was being rubbed with sandpaper" when her partner penetrated her. Although the physical pain had not actually returned in subsequent lovemaking sessions, Gina's fear of the pain recurring diminished both her interest in and her enjoyment of sex. When asked what she would do if the pain happened again during intercourse, Gina replied that she "would have to ask him to hurry up, but sometimes he lasts longer then." The physician asked how she would feel about telling him to stop all movement immediately and to withdraw when she felt discomfort or pain. Gina expressed concern that an abrupt withdrawal from intercourse might result in her boyfriend having testicular pain. She was reassured that this would create no lasting discomfort for him, and that there were alternatives for reaching ejaculation and orgasm, either with her or alone (P, LI, and SS). She was also offered some suggestions for reading about how couples learn to increase their enjoyment of sex (SS). The physician also praised Gina for having shown the courage to discuss this personal issue and encouraged her to bring up any future concerns (P, LI).

## Management

**Specific Suggestions:** These issues can be approached gradually, by encouraging the woman to speak with her partner about her needs and to be a full participant in the sexual encounter, educating her and her partner about the need both for sufficient stimulation and arousal prior to attempted penetration, and for her to be in control of the sexual movement, so that she can be assured that she can stop instantly if pain is felt. Instruction in Kegel's pubococcygeal muscle exercises increases the woman's awareness and control of her vaginal muscles. Vaginal self-dilatation can be accomplished with graduated cylinders or with fingers, from the little finger to multiple fingers, while practicing muscle relaxation and calming mental imagery. The patient should be encouraged to be the one in control by bearing down on the finger(s) or penis as if pushing something out of the vagina, then relaxing. It helps for some women to imagine "capturing" the penis or other object in this manner, instead of being "penetrated."

**Other Medical Interventions:** Other medical suggestions include the use of artificial lubricants,

such as Astroglide, Gyne-Moistrin, or KY Jelly; vaginal moisturizers, such as Replens; vaginal and vulva application of estrogen creams; surgical repair of the vulvar region; and excision of abnormal growths in the genital area. Diseases thought to cause the pain, such as vaginitis, condylomata, endometriosis, pelvic inflammatory disease, and other gynecologic or pelvic diseases, all may be treated directly. When painful intercourse has been a long-standing problem, however, medical intervention alone is seldom adequate and should be followed by sex therapy directed at the probable fear and expectation of pain that have been conditioned.

## SEXUAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION

*Case illustration 10:* When Hannah was 22, she was diagnosed with clear cell adenocarcinoma of the vagina and had surgery that removed one ovary, her uterus, tubes, the upper two thirds of her vagina, and her bilateral pelvic lymph nodes. None of her health care team was able to comfortably discuss sexuality with her. She was completely unprepared for the first attempts at intercourse several months following the surgery and was shocked and distraught to discover how little genital sensation she had left. She sought help from a male psychiatrist who listened as she expressed her grief and fears that she would never find a man because of her sense of diminished sexual self-worth. After rapport was established, he acknowledged her fears by saying that she might never have a "clitoral" orgasm again, but that there were other routes to orgasm and sexual pleasure. He discussed with her ideas that have been helpful to others who have sustained the loss of genital sensation: that her brain knew how to feel pleasure and have orgasms, that men and women can learn to focus on sensations from other, nongenital parts of the body, such as breasts, neck, ears, and lips, and that with or without accompanying fantasy, one can thus relearn to enjoy a sense of orgasmic release and pleasure. Twelve years after her surgery, Hannah wrote, "The growth in my ideas and experiments with sexuality have increased manyfold since my surgery. What was most helpful was being able to share my experiences with people who could understand and be accepting, and finding people who were trained and had accurate information on how I could help myself. Health professionals don't have to have all the answers, but they should know of their own limitations and be able to refer when necessary."

## OTHER SEXUAL PROBLEMS NOT OTHERWISE SPECIFIED

It would take a full textbook to describe and give treatment suggestions for the wide variety of additional sex-related human problems. A patient with truly compulsive sexual behavior—sometimes described as sexual addiction—may be suffering from a form of obsessive compulsive disorder and may re-



quire intensive psychotherapy, use of support groups, and medications such as the SSRI antidepressants. Gender identity disorders require referral for specialized treatment, as do issues of spousal abuse, incest, and rape, and patients troubled by paraphilias.

## CONCLUSION

For every human being, sexuality—like health—is a challenge at some point. Feelings of personal vulnerability are inherent in sexual interactions and help

to make sexuality a powerful and unique part of life. Problems of sexual desire, arousal, or functioning can lead us to confront and overcome our fears of not being lovable and to seek better communication and increased intimacy with others. The deepest expressions of love often result from just such a sharing of our vulnerabilities or problems.

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